Regional Support Team Referral Form

Community Integration Manager

Training Center:	Date of request:	Unique identifier:
Submitted by:	Agency:	Phone:

Referral Reason (check only one)		**Issues and actions taken** (as applicable):
☐	a. Recommended to move to a nursing home, ICF or group home with five or more individuals.	a. Describe the reason(s) for selection and whether the informed choice of provider process has been followed:
☐	b. Difficulty finding particular type of community supports within 90 days of discharge plan during 2013.	b. Describe gaps/barriers and what has been tried and learned:
☐	c. PST cannot agree on a discharge plan outcome within 15 days of the annual PST meeting, or within 30 days after the admission to the Training Center.	c. Describe difficulty with outcome development and what has been considered?
☐	☐ d-1. Individual or AR opposes moving despite PST recommendation ☐ d-2. Individual or AR refuses to participate in the discharge planning process.	d. Describe the reason(s) for opposition to move and what has been tried and learned:
☐	e. Hasn't moved within three months of selecting a provider (requires identifying the barriers to discharge and notifying the facility director and the CIM).	e. Describe the reason(s) for delay in moving and what has been tried and learned:
☐	f. Recommended to remain in a Training Center (requires PST/CIM assessment at 90-day intervals).	f. Describe the reason(s) for continued Training Center supports/services:
☐	g. Other	g. Describe assistance needed/barriers, reason for referral or additional comments:

Community Supports

Describe the individual's good life					
	Planned	Needed		Planned	Needed
ID Waiver	☐	☐	Specialized Medical	☐	☐
AR/Guardian	☐	☐	Experience with Autism Spectrum	☐	☐
Skilled Nursing (RN/LPN)	☐	☐	Employment/Day Services	☐	☐
Behavioral Supports (PBS/ABA)	☐	☐	Environmental Modifications	☐	☐
Therapeutic Consult other:	☐	☐	Assistive Technology	☐	☐
Psychiatric/MH/Substance Abuse	☐	☐	Other:	☐	☐

CIM Completion Only

CIM recommendations:

Facility director notified (Item e above)? ☐ yes ☐ no

RST referral needed? ☐ yes ☐ no; **If yes, date of RST meeting:**

Meeting method: ☐ conference call at: (time) ☐ in person at: (location/time)

RST Recommendations (if applicable):

#	Action	Responsible Person	Complete by date

Resolution

Provided by: Date: